

Tennessee Society of Interventional Pain Physicians
American Society of Interventional Pain Physicians®

"The Voice of Interventional Pain Management"

81 Lakeview Drive, Paducah, KY 42001

Phone: (270) 554-9412 - Fax : (270) 554-5394

www.asipp.org

November 8, 2013

Dr. Andrea Willis, MD
Medical Director, Blue Cross Blue Shield of Tennessee
1 Cameron Hill Circle
Chattanooga, TN, 37402-2555
medical_policy@bcbst.com
andrea_willis@bcbst.com

RE: Cervical Epidural Steroid Injections for the Treatment of Pain

Dr. Willis:

On behalf of the Tennessee Society of Interventional Pain Physicians (TNSIPP) and American Society of Interventional Pain Physicians (ASIPP), we would like to thank you for publishing the updated medical policy for cervical epidural injections. However, we are very much concerned with the development of the policy and its implications of noncoverage. Consequently, we would like to provide comments with the primary objective to ensure that cervical epidural injections are provided appropriately and the patients insured by Blue Cross Blue Shield of Tennessee maintain access to care. We are hopeful that you will reconsider the policy by appropriately interpreting the evidence and reverse the proposed decision of noncoverage.

Based on an appropriate analysis of the available evidence utilizing IOM principles for preparing systematic reviews and guidelines, there is moderate to good evidence for epidural injections in managing pain of cervical origin. In recent systematic reviews by Diwan et al (1), the evidence-based guidelines by Manchikanti et al (2) based on multiple randomized controlled trials, fair to good evidence has been demonstrated in managing cervical disc herniation and radiculopathy (3-8), cervical spinal stenosis (9), cervical post surgery syndrome (10), and axial neck pain without disc herniation, radiculitis, or facet joint pain (11,12).

BACKGROUND INFORMATION:

ASIPP is a not-for-profit professional organization comprising over 4,500 interventional pain physicians and other practitioners who are dedicated to ensuring safe, appropriate and equal access to essential pain management services for patients across the country suffering with chronic and acute pain. There are approximately 8,500 appropriately trained and qualified physicians practicing interventional pain management in the United States.

TNSIPP is a state organization of ASIPP with membership of over 100.

Interventional pain management is defined as the discipline of medicine devoted to the diagnosis and treatment of pain-related disorders principally with the application of interventional techniques in managing subacute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatment (13).

Interventional pain management techniques are minimally invasive procedures including percutaneous precision needle placement, with placement of drugs in targeted areas or ablation of targeted nerves and some surgical techniques such as laser or endoscopic discectomy, intrathecal infusion pumps and spinal cord stimulators for the diagnosis and management of chronic, persistent or intractable pain (14).

EVIDENCE SYNTHESIS

There has been a growing emphasis on evidence synthesis and development of guidelines based on systematic reviews with the Institute of Medicine (IOM) re-engineering its definition of clinical guidelines in 2011 (15). Accordingly, the new definition emphasizes that “clinical practice guidelines are statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternate care options.” Thus, the new definition departs from a 1990 IOM report, which defined guidelines as, “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances” (16).

The new definition provides a clear distinction between the term “clinical practice guideline” and other forms of clinical guidance derived from widely disparate development processes, such as consensus statement, expert advice, and appropriate use criteria. In addition, the new definition also underscores systematic review and both benefits and harms assessment as essential components of clinical practice guidelines. While any group of individuals can designate itself as an evidence-based medicine, comparative effectiveness research or guideline group, they may reach different conclusions based on various interests (15). However, IOM provided guidance for trustworthy guidelines, noting that they should be:

1. Based on a systematic review of the existing evidence
2. Developed by a knowledgeable, multidisciplinary panel of experts and representatives from key affected groups
3. Considerate of important patient subgroups and patient preferences, as appropriate
4. Based on an explicit and transparent process that minimizes distortions, biases, and conflicts of interest
5. Clear in their explanation of the logical relationships between alternative care options and health outcomes, and provide ratings of both the quality of evidence and the strength of recommendations
6. Reconsidered and revised as appropriate when important new evidence warrants modifications of recommendations.

Appropriately developed guidelines must incorporate validity, reliability, reproducibility, clinical applicability, flexibility, clarity, development through a multidisciplinary process, scheduled reviews, and documentation (17). When appropriately applied, rigorously developed guidelines have the potential to reduce undesirable practice variation, reduce the use of services that are of minimal or questionable value, increase utilization of services that are effective, but underused, and target services to those populations most likely to benefit.

Interventional pain management is an emerging specialty. As many providers are concerned, there has been significant growth of all modalities of treatments and continuing development of evidence synthesis when compared to the lumbar spine. Cervical modalities only constitute a small proportion. Even then, appropriate utilization is essential.

In preparing guidelines and systematic reviews, it is essential to apply methodologic quality or validity assessment of all included manuscripts, rather than utilizing individual opinions. Further, this process

should be transparent and available to the public. As the policy shows for cervical epidural injections, Hayes guidelines are used as a reference. These are not available openly to the public. They are not scrutinized or peer-reviewed. Similarly, Milliman guidelines follow the same principles competing for business from industry, as well as the provider community. To subscribe to these guidelines, it costs a physician tens of thousands of dollars. Consequently, any conclusions recommended by organizations without transparency and free availability and publication in peer-reviewed journals, that lack listing on the Agency for Healthcare Research and Quality (AHRQ) National Guidelines Clearinghouse (NGC), and that are expensive to review, must be abandoned.

In grading the overall strength of evidence for an intervention, the United States Preventive Services Task Force (USPSTF) (18) has established 2 systems which classify the strength as good, fair, and limited or poor, and Grade I to III.

Table 1. *Method for grading the overall strength of evidence for an intervention.*

Grade	Definition
Good	Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes (at least 2 consistent, higher-quality RCTs or studies of diagnostic test accuracy).
Fair	Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, size, or consistency of included studies; generalizability to routine practice; or indirect nature of the evidence on health outcomes (at least one higher-quality trial or study of diagnostic test accuracy of sufficient sample size; 2 or more higher-quality trials or studies of diagnostic test accuracy with some inconsistency; at least 2 consistent, lower-quality trials or studies of diagnostic test accuracy, or multiple consistent observational studies with no significant methodological flaws).
Limited or Poor	Evidence is insufficient to assess effects on health outcomes because of limited number or power of studies, large and unexplained inconsistency between higher-quality trials, important flaws in trial design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

Adapted and modified from methods developed by U.S. Preventive Services Task Force (18).

Table 2. *Quality of evidence developed by AHRQ.*

I:	Evidence obtained from at least one properly randomized controlled trial.
II-1:	Evidence obtained from well-designed controlled trials without randomization.
II-2:	Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.
II-3:	Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940s) could also be regarded as this type of evidence.
III:	Opinions of respected authorities, based on clinical experience descriptive studies and case reports or reports of expert committees.

Adapted from the Agency for Healthcare Research and Quality, U.S. Preventive Services Task Force (18).

Methodology is not the only essential criteria, but understanding the technique and unbiased assessment is essential. This should include, as stated in the USPSTF or any other methodology of strength of evidence, the exact statement rather than injection of multiple philosophies to discredit or disapprove a treatment. By the same token, it also applies in reference to the negative evidence and its inclusion by all cervical epidural injections.

Consequently, guidelines from ASIPP (2) utilizing IOM criteria of systematic reviews and guideline preparation have taken a balanced approach and showed that of all the therapeutic interventions assessed, only 52% received a grading of fair to good.

CERVICAL EPIDURAL INJECTIONS

Chronic, persistent neck and upper extremity pain and radicular pain may be secondary to disc herniation, discogenic pain, spondylosis, spinal stenosis, or post cervical surgery syndrome resulting in disc-related pain with or without radiculitis.

Cervical epidural injections have been used to treat radicular pain from herniated discs, spinal stenosis, chemical discs, chronic neck pain with or without radiculitis secondary to post cervical surgery syndrome, and chronic neck pain of discogenic origin. The interlaminar approach is the most commonly applied modality in managing cervical discogenic pain.

While there are multiple systematic reviews and guidelines, recently Diwan, et al (1), in a systematic review which has been quoted in your manuscript, with literature included through December 2011, assessed the evidence with inclusion of 7 randomized trials (3,4,6-12). They showed good evidence for epidural injections in treating cervical disc herniation, and fair evidence for axial or discogenic pain without facet joint pain, central spinal stenosis, and post cervical surgery syndrome. Later, the literature search by Manchikanti et al in 2013 (2) identified additional studies; however none of them met inclusion criteria. Since the publication of “An update of comprehensive evidence-based guidelines for interventional techniques of chronic spinal pain: Part II: Guidance and recommendations” (2), there have been 2 recent publications with an update of the management of axial or discogenic pain and disc herniation (5,12).

While we will be available to provide you with detailed information, the following table shows the results of randomized trials of the effectiveness for cervical interlaminar epidural injections.

Table 3. Results of randomized trials of effectiveness of cervical interlaminar epidural injections.

Study Study Characteristics Methodological Quality Scoring	Participants	Interventions	Pain Relief and Function			Results			Comment(s)
			3 mos.	6 mos.	12 mos.	Short-term ≤ 6 mos.	Long-term		
							> 6 mos.	1 year	
DISC HERNIATION AND RADICULITIS									
Manchikanti et al (3-5) RA, AC, F 11/12	120 local anesthetic= 60 Local anesthetic with steroids = 60	Local anesthetic or with Celestone Number of injections = 1 to 4	83% vs. 70%	82% vs. 73%	72% vs. 68%	P	P	P	Positive large study.
Castagnera et al (6) RA, AC, B 7/12	24	local anesthetic with steroid or steroid plus morphine Number of injections=1	79.2%	79.2%	79.2%	P	P = steroids N = local anesthetics	P	A small study with positive results
Stav et al (7) RA, AC, B 7/12	42	local anesthetic with steroid or IM steroid Number of injections=1 to 3	NA	NA	68% vs.11.8%	NA	NA	P	A small study showing satisfactory improvement
Pasqualucci et al (8) RA, AC, B 7/12	40 of 160	Bupivacaine with methylpredniso lone acetate	NA	Single vs. continuous 58.5%, 73.7% improvement	NA	NA	P	NA	Small study with positive results
DISCOGENIC PAIN									
Manchikanti et al (11,12) RA, AC, F 10/12	120	Local anesthetic or with Celestone	68% vs. 77%	67% vs. 73%	72% vs. 68%	P	P	P	Positive results
SPINAL STENOSIS									
Manchikanti et al (9) RA, AC, F 10/12	60	Local anesthetic or with Celestone	77% vs. 87%	87% vs. 80%	73% vs. 70%	P	P	P	Positive results
POST SURGERY SYNDROME									
Manchikanti et al (10) RA, AC, F	56	Local anesthetic or with Celestone	68% vs. 68%	64% vs. 71%	71% vs. 64%	P	P	P	Positive results

Study Characteristics Methodological Quality Scoring	Participants	Interventions	Pain Relief and Function			Results			Comment(s)
			3 mos.	6 mos.	12 mos.	Short-term ≤ 6 mos.	Long-term		
							> 6 mos.	1 year	
10/12									

RA = Randomized; AC = Active-Control; F = Fluoroscopy; B=Blind; P = positive; N = negative; NA = not applicable

Source: Diwan SA, Manchikant L, Benyamin RM, Bryce DA, Geffert S, Hameed H, Sharma ML, Abdi S, Falco FJE. Effectiveness of cervical epidural injections in the management of chronic neck and upper extremity pain. *Pain Physician* 2012; 15:E405-E434 (1).

Based on the present review of evidence, there is good evidence for disc herniation and fair evidence for axial or discogenic pain, central spinal stenosis, and post cervical surgery syndrome. Thus, cervical interlaminar epidural injections are indicated for these conditions with appropriate indications.

COMPARISON OF EVIDENCE SYNTHESIS PUBLISHED BY BLUE CROSS BLUE SHIELD OF TENNESSEE

The policy quotes Hayes guidelines and states that policy is also similar to Milliman guidelines. However, as stated earlier, this is inappropriate as these guidelines are commercial, prepared with the purposes of providing recommendations to the industry with no peer review. They are expensive for a clinician to review them and they are not published on the NGC.

The cervical epidural policy information shows that,

“The current body of literature shows that CESIs are associated with some pain relief. However, the studies are variable in design. Well-designed studies that compare conservative management to CESI are needed. Well-designed studies that compare CESI with and without an anesthetic agent are needed. Trials are also needed that include longer follow-up in order to adequately examine the duration of any benefit associated with CESIs.”

In contrast to this recommendation, there are multiple well-designed studies as shown above including a large number of patients for each condition studied. In fact, there are multiple studies for cervical disc herniation. The current policy has utilized outdated guidelines, even though the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine guidance was published in 2010. The evidence was only through 2009. Since then, there have been multiple manuscripts published. Even then, this guideline provides positive evidence for epidural injections. Armon, et al’s reference was from 2007 and was limited to assessment of radicular lumbosacral pain as the title itself says.

The review by Benjamin is also old. It has been updated by Diwan, et al.

ASIPP guidelines utilized are from 2007 and 2009; however, these have been updated in 2013 as illustrated above.

North American Spine Society (NASS) guidelines were developed by surgeons, once again published in 2011 without inclusion of all up to date evidence.

In contrast to this, the above described evidence shows up-to-date literature with proper quality assessment and utilization of proper criteria in grading the strength of evidence.

INDICATIONS, MEDICAL NECESSITY, TRAINING AND QUALIFICATIONS

It is essential to apply proper indications and medical necessity.

Common indications for cervical interlaminar epidurals are as follows:|

- Chronic neck and/or upper extremity pain of at least 3 months duration which has failed to respond or poorly responded to non-interventional and non-surgical conservative management resulting from:
- Disc herniation/cervical radiculitis (evidence – good)

- Cervical spinal stenosis (evidence – fair)
- Post cervical surgery syndrome (evidence – fair)
- Axial or discogenic pain without facet joint pathology or disc herniation (evidence – fair)
- Intermittent or continuous pain causing functional disability.

Frequency:

- In the diagnostic phase, a patient may receive 2 procedures at intervals of no sooner than 2 weeks or preferably 4 weeks.
- In the therapeutic phase (after the diagnostic phase is completed), the suggested frequency of interventional techniques should be 3 months or longer between each injection, provided that > 50% relief is obtained for 2½ to 3 months
- In the treatment or therapeutic phase, the epidural injections should be repeated only as necessary according to medical necessity criteria, and it is suggested that these be limited to a maximum of 4 times per year.

DOCUMENTATION REQUIREMENTS

1. Complete initial evaluation including history and physical examination.
 - ◆ Physiological and functional assessment, as necessary and feasible.
 - ◆ Description of indications and medical necessity, as follows:
 - Suspected organic problem.
 - Pain and disability of moderate-to-severe degree.
 - ◆ No evidence of contraindications, such as severe spinal stenosis resulting in intraspinal obstruction, infection, or predominantly psychogenic pain.
 - ◆ Nonresponsiveness to conservative modalities of treatment.
 - ◆ Responsiveness to prior interventions with improvement in physical and functional status for repeat blocks or other interventions with appropriate consideration to the adverse effects including those of corticosteroids.

Patient safety and quality care mandate the healthcare professionals who perform any interventional techniques as defined by MedPAC are performed by appropriately trained providers who have:

- ◆ Successfully completed an accredited residency or fellowship program whose core curriculum includes the performance of interventional techniques, and/or
- ◆ Are diplomates of nationally recognized boards, such as those accredited by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA), subspecialty certification in pain medicine; the American Board of Pain Medicine (ABPM); or the American Board of Interventional Pain Physicians (ABIPP).

Exceptions for these requirements include a formal residency or fellowship program with curriculum including interventional techniques, with documentation of such curriculum and training requirements.

At a minimum, training must cover and develop an understanding of anatomy and drug pharmacodynamics and kinetics as well as proficiency in diagnosis and management of disease, the technical performance of the procedure and utilization of the required associated imaging modalities.

An exception is also provided to all physicians who have been performing these procedures for at least 10 years on a regular basis with credentials approved by either a CMS-accredited hospital or a surgery center.

IMAGING:

The use of imaging guidance, particularly fluoroscopy or computed tomography, with the use of injectable radiopaque contrast material has been shown to enhance the accuracy and safety of needle placement for all epidural injection procedures, including cervical interlaminar epidural injections. Consequently, imaging guidance must be mandated except when it is contraindicated.

CONCLUSION:

In conclusion, we appreciate the efforts to establish standards. However, the process utilized does not appear to be scientific. Based on this, we would recommend that the policy be reversed and cervical epidural injections be covered for disc herniation, axial neck or discogenic pain without facet joint pain, spinal stenosis, and post surgery syndrome. However, it is essential to establish appropriate indications and medical necessity. The policy must also include appropriate training and settings for these procedures to be performed.

Once again, thank you for the opportunity to provide these comments. If you have any further questions, please feel free to contact us.

Sincerely,

ASIPP Board

TNSIPP

Laxmaiah Manchikanti, MD

Chairman of the Board and Chief Executive Officer, ASIPP and SIPMS
Medical Director, Pain Management Center of Paducah
Clinical Professor
Anesthesiology and Perioperative Medicine
University of Louisville, Kentucky
2831 Lone Oak Road
Paducah, KY 42003
Phone: 270-554-8373 ext. 101
Fax: 270-554-8987
drm@asipp.org

Hans C. Hansen, MD

President, ASIPP
Medical Director
The Pain Relief Centers, LLC
224 Commerce St
Conover, NC 28613
Phone: (828) 261-0467
Fax: (828) 261-7293
hhansen@painreliefcenters.com

Graf Hilgenhurst, MD

President and CEO, TNSIPP
Precision Pain Care
1177 Rock Springs Road, Suite A
Smyrna, TN 37167-8412
Phone: 615-223-6300
ghilgenhur@aol.com

William Newton, DO, MS

Vice President/President Elect
Tennessee Society of Physical Medicine & Rehabilitation
Treasurer, TNSIPP
Spine Joint & Pain Center
Murfreesboro Medical Clinic
1272 Garrison Drive, Suite 302
Murfreesboro, TN 37129
Office: 615-867-7971
Fax: 615-867-7974
wnewton@mmclinic.com

John R. Schneider, MD, MA

Frank J. E. Falco, MD
Immediate Past President
Medical Director, Midatlantic Spine
139 East Chestnut Hill Road
Newark, DE 19713
Clinical Assistant Professor
Temple University Medical School
Philadelphia, PA
Phone: (302) 369-1700
Fax: (302) 369-1717
cssm01@aol.com

Ramsin M. Benyamin, MD
President-Elect, ASIPP
Medical Director, Millennium Pain Center
1015 South Mercer
Bloomington, IL 61701
Phone: (309) 662-4321
Fax: (309) 661-4532
ramsinbenyamin@yahoo.com

David L. Caraway, MD, PhD
First Executive Vice President, ASIPP
St. Mary's Pain Relief Center
2900 1st Avenue, 1 East
Huntington, WV 25702
Phone: (304) 526-7246
Fax: (304) 526-8389
carawaymd@aol.com

Aaron K. Calodney, MD
Second Executive Vice President, ASIPP
NeuroCareNetwork
P.O. Box 130459
Tyler, TX 75713-0459
Phone: (903) 531-2500
Fax: (903) 597-8997
aaroncalodney@me.com

Francis Riegler, MD
Vice President Strategic Planning, ASIPP
Universal Pain Management
819 Auto Center Drive
Palmdale, CA 93551
Phone: (661) 267-6876

Vice President, TNSIPP
Vice President, Tennessee Pain Society
Medical Director and President
Comprehensive Pain & Neurology Center,
PLLC
317 Seven Springs Way, Suite 201
Brentwood, TN 37027
Phone: (615) 410-4990
schneider.john.r@gmail.com

Damon Dozier MD, MS
Director-at-Large, TNSIPP
Pain Management of Middle Tennessee
Clarksville TN 37040
dpauldozier@gmail.com

Thomas P. Miller, MD
Director-at-Large, TNSIPP
Specialist in Pain Management, P.C.
2339 McCallie Avenue, Suite 309
Chattanooga, TN 37404
Phone: 423-698-0850
sleepdoc9@aol.com

Autry Parker, MD
Director-at-Large, TNSIPP
Parker Pain Rehabilitation Center
6005 Park Avenue #802
Memphis, TN 38119
Phone: 901-763-0037
autryparker@msn.com

Timothy S Smyth, MD
Director-at-Large, TNSIPP
Pain Medicine Associates
101 MedTech Pkwy #200
Johnson City TN 37604
Phone: 423-232-6120
tssmyth@mindspring.com

John Blake, MD
Kentucky Alternate CAC Representative
4306 Asheville Hwy
Knoxville, TN 37914
Phone: 865-522-2168
rettblake@yahoo.com

Fax: (661) 538-9483
friegler@upmgt.com

Peter S. Staats, MD
Secretary, ASIPP
Premier Pain Centers, LLC
160 at the Commons, Suite 1
Shrewsbury, NJ 07702
Phone: (732) 380-0200
peterstaats@hotmail.com

David A. Bryce, MD
Treasurer, ASIPP
Advanced Pain Management
34 Schroeder Court.
Madison, Wisconsin, 53711
tonys09@gmail.com

Salahadin Abdi, MD, PhD
Director-at-Large, ASIPP
MD Anderson Cancer Center
Professor and Chair
Department of Pain Medicine
Phone: 713-792-0883
Fax: 713-745-0177
sabdi@mdanderson.org

Mark V. Boswell, MD, PhD
Director-at-Large, ASIPP
Professor & Chairman
Sam & Lolita S. Weakly Endowed
Research Chair
Department of Anesthesiology and
Perioperative Medicine
530 S. Jackson Street, Room C2A01
Louisville, KY 40202
(502) 852-5851
boswellmv@earthlink.net

Harold Cordner, MD
Director-at-Large, ASIPP
Florida Pain Management Associates
13825 U.S. Hwy 1
Sebastian, FL 32958
gassdoc@aol.com

Keith G. Anderson, MD
Chairman of the Board,
Kentucky Medical Association
7460 Wolf River Blvd.
Germantown, TN 38138
Phone: 901-763-0200

Chris E. Young, MD
President, Kentucky Medical Association
975 E 3rd Street
Chattanooga, TN 37403
Phone: 423-778-700

Vidya R. Bethi, MD
482 Warfield Blvd
Clarksville, TN 37043
Phone: 931-906-6644
mbethi@yahoo.com

James J. Choo, MD
Pain Consultants of East Tennessee
1128 E. Weisgarber Road, Suite 100
Knoxville, TN 37909
T-(865) 579-0552
F-(865) 579-1154

John W. Culclasure, MD
Neurological Associates
11 Murphy Ave #301
Nashville, TN 37203
Phone: 615-327-9543
gasmdx@yahoo.com

Joe H. Browder, MD, MBA
Pain Consultants of East Tennessee
1128 E. Weisgarber Road, Suite 100
Knoxville, TN 37909
T-(865) 579-0552
F-(865) 579-1154
jbrowder@painconsultants.com

Gilberto Carrero, MD
Anesthesia Services Associates PLLC
131 Saundersville Road, Suite 160
Hendersonville, TN 37075
Phone: 615-239-2036
tito.carrero@comcast.net

Timothy Deer, MD

Director-at-Large, ASIPP
The Center for Pain Relief
400 Court St # 302,
Charleston, WV 25301
(304) 344-8012
DocTDeer@aol.com

Sudhir Diwan, MD

Director-at-Large, ASIPP
Executive Director
Manhattan Spine and Pain Medicine, PC
115 East 57th Street
New York, NY 10022
sudhir.diwan63@gmail.com

Haroon Hameed, MD

Director-at-Large, ASIPP
Spine Care Center
8525 Rolling Road, Suite 200
Manassas, VA 20110
Phone: (703) 257-2266
drharoonhameed@hotmail.com

Joshua A. Hirsch, MD

Director-at-Large, ASIPP
Mass General Hospital
Boston, MA 02114
Phone: (617) 726-1767
Fax: 617-726-3089
Hirsch@snisonline.org

Alan D. Kaye, MD, PhD

Director-at-Large, ASIPP
Louisiana State University School of
Medicine
Chairman, Department of Anesthesia
Professor of Anesthesia
1542 Tulane Ave., Rm. 659
New Orleans, LA 70112
Phone: (504) 568-2315
alankaye44@hotmail.com

Allan T. Parr, MD

Director-at-Large, ASIPP
Medical Director, Premier Pain Center

David J. Dowling, MD

OrthoMemphis Spine Center
6286 Briarcrest Avenue, Suite 200
Memphis, TN 38120
Phone: 901-259-1600
ddowling@orthomemphis.com

John D. Dockery, MD

Campbell Clinic Orthopaedics
1400 S Germantown Rd
Germantown, TN 38138
Phone: 901-759-3100
jdockery@campbellclinic.com

Neal Frauwirth, MD

Center for Pain Management
63 Mouse Creek Rd NW
Cleveland, TN
Phone: 423-790-5672
ufcdoc@gmail.com

James Freidenstein, MD

Synergy Health Systems, PLLC
7220 Westhampton Place
Knoxville, TN 37919
freidenstein@hotmail.com

Marc Huntoon, MD

3241 Blazer Road
Franklin, TN 37064
Phone: 615-875-6354
Huntoondoc@yahoo.com

**Bart Huddleston, MD, FAAPMR,
DAAPM**

Center for Spine, Joint, and Neuromuscular
Rehabilitation
833 Memorial Blvd.
Murfreesboro, TN 37129
Phone: 615-513-9326
bhuddleston@sjnmr.com

Ihab Labatia, MD, ABIPP

East TN Brain and Spine Center
Johnson City, TN
Phone: 423-557-9065

7015 Highway 190, Service Road, Suite 101

Covington, LA 70433

Phone: (985) 809-1997

Fax: (985) 809-1664

alparr@alparr.com

Gabor B. Racz, MD

Director-at-Large, ASIPP

Chairman Emeritus and Director of Pain Services,

Texas Tech University Health Sciences Center

3601 4th St.

Lubbock, TX 79430

Phone: (806)-743-3112

Fax: (806)-743-3965

paula.brashear@ttuhsc.edu

David M. Schultz, MD

Director-at-Large, ASIPP

Medical Director

Medical Advanced Pain Specialists

2104 Northdale Blvd. NW Suite 220

Minneapolis, MN 55433

Phone: (763) 537-6000

Fax: (763) 537-6666

dschultz@painphysicians.com

Vijay Singh, MD

Lifetime Director, ASIPP

Medical Director

Pain Diagnostics Associates

1601 Roosevelt Road

Niagara, WI 54151

Phone (715) 251-1780

Fax (715) 251-1812

vj@wmpnet.net

Cyrus E. Bakhit, MD

Lifetime Director, ASIPP

Medical Director

Pain Management Center of Roanoke

2110 Carolina Ave., 2nd floor

Roanoke, VA 24014

Phone: (540) 345-4230

ilabatia@hotmail.com

Son D. Le, MD

CEO/Founder

Center for Spine, Joint, and Neuromuscular Rehabilitation, P.C.

5651 Frist Blvd Ste 712

Brentwood / Cool Springs

Spine & Sports Medical Plaza

1605 Westgate Circle, Suite 200

Brentwood, TN 37027

Phone: 615-515-9311

sdl@sjnmr.com

Kit S. Mays, MD

Mays and Schnapp Pain Clinic and

Rehabilitation Center

55 Humphreys Center Dr., Ste.200

Memphis, TN 38120-

Phone: 901-747-0040

kitm321@aol.com

Marshall Millman, MD, PhD

Anesthesia/Pain Management Services

2345 Murfreesboro Hwy.

Manchester, TN 37349

Phone: 800-831-3471

marshmill@comcast.net

Anna-Louise O. Molette, MD, ABPMR

Southern Pain Institute

739 President Place Ste 220

Smyrna, TN 37167

Phone: 615-459-3244

connemd@aol.com

John Nwofia, MD, FAAPMR

Pain and Spine Consultants

1805 Williamson Court

Brentwood, TN 37207

Phone: 615-331-5536

jnwofia@yahoo.com

Bethany M. Owen, MD

Mays and Schnapp Pain Clinic and

Rehabilitation Center

Fax: (540) 345-6458
cbakhit@pmcr.org

John R. Swicegood, MD, FIPP, DABIPP

Director-at-Large, ASIPP
Advanced Interventional Pain and
Diagnostics
P.O. Box 10206
Fort Smith, AR 72903
Phone: (479) 452-0882
Fax: (479) 314-5698
swice99@gmail.com

Andrea M. Trescot, MD

Director-at-Large, ASIPP
Pain and Headache Center
10928 Eagle River Rd, Suite 254
Eagle River, AK 99677
Phone: 907-980-7507
Fax: 907-694-5524
drtrescot@gmail.com

Standiford Helm II, MD

Director Emeritus, ASIPP
Medical Director,
The Helm Center for Pain Management
24902 Moulton Pkwy, Suite 200
Laguna Hills, CA 92637
Phone: (949) 462-0560
Fax: (949) 462-3910
drhelm@thehelmcenter.com

David S. Kloth, MD

Director Emeritus, ASIPP
Executive Director, CTSIPP
President Elect, NANS
Medical Director, Connecticut Pain Care
109 Newtown Road
Danbury, CT 06810
Phone: (203) 792-5118
Fax: (203) 792-9636
dkmd@ctpaincare.com

Lee T. Snook, Jr., MD

AMA Representative, ASIPP
Medical Director

55 Humphreys Center Dr., Ste.200
Memphis, TN 38120-
Phone: 901-747-0040
bethanyowen3@yahoo.com

Elmer Pinzon, MD

Medical Director and President,
University Spine & Sports Specialists,
PLLC
110 Center Park Drive, Suite 103
Knoxville, TN 37922
Phone: 865-690-3737
docelpinzon@charter.net

Eric Redmon, MD

Ambulatory Core Center of Wartburg
1236 Knoxville Highway
Wartburg, TN 37887
Phone: 423-346-5566
eredmon@ntown.com

L. Shay Richardson, MD

Center for Sports Medicine and
Orthopaedics
2415 McCallie Avenue
Chattanooga, TN 37404
Phone: 423-341-8266
lshayrichardsonmd@gmail.com

Carlos Rivera, MD

Campbell Clinic
1400 S. Germantown Road
Germantown, TN 38138
Phone: 901-759-3101
crivera@campbellclinic.com

Matt Rupert, MD, MS, FIPP, DABIPP

Vertex Spine & Pain
100 Covey Drive, Suite 103
Franklin, TN 37067
Phone: 615-550-8500
mattrupert@comcast.net

Moacir Schnapp, MD

Mays and Schnapp Pain Clinic and
Rehabilitation Center
55 Humphreys Center Dr., Ste.200

Metropolitan Pain Management
Consultants, Inc.
2288 Auburn Blvd., Suite 106
Sacramento, CA 95821
Phone: 916.568.8338
LSnook@pain-mpmc.com

Memphis, TN 38120-
Phone: 901-747-0040
vfsaunders@mspainclinic.com

Igor Smelyansky, MD
Advanced Spine and Pain
3496 N. Main Street
Crossville, TN 38555
Phone: 931-484-2727
igornyus@gmail.com

Michael J. Sorensen, MD
Board Certified Physical Medicine and
Rehabilitation
Subspecialty Certification Pain Medicine
OrthoMemphis
6286 Briarcrest Avenue, Suite 100
Memphis, TN 38120
Phone: 901-259-1600
Fax: 901-259-1698
msorensen@orthomemphis.com

Steven A. Urban, MD
Tennessee Physical Medicine and
Pain Management
1423 Baddour Parkway
Lebanon, TN 37087
Phone: 615-306-7601
skurban07@aol.com

REFERENCES

1. Diwan SA, Manchikanti L, Benyamin RM, et al. Effectiveness of cervical epidural injections in the management of chronic neck and upper extremity pain. *Pain Physician* 2012; 15:E405-E434.
2. Manchikanti L, Abdi S, Atluri S, et al. An update of comprehensive evidence-based guidelines for interventional techniques of chronic spinal pain: Part II: Guidance and recommendations. *Pain Physician* 2013; 16:S49-S283.
3. Manchikanti L, Cash KA, Pampati V, Wargo BW, Malla Y. The effectiveness of fluoroscopic cervical interlaminar epidural injections in managing chronic cervical disc herniation and radiculitis: Preliminary results of a randomized, double-blind, controlled trial. *Pain Physician* 2010; 13:223-236.
4. Manchikanti L, Cash KA, Pampati V, Wargo BW, Malla Y. Management of chronic pain of cervical disc herniation and radiculitis with fluoroscopic cervical interlaminar epidural injections. *Int J Med Sci* 2012; 9:424-434.
5. Manchikanti L, Cash KA, Pampati V, Wargo BW, Malla Y. A randomized, double-blind, active control trial of fluoroscopic cervical interlaminar epidural injections in chronic pain of cervical disc herniation: Results of a 2-year follow-up. *Pain Physician* 2013; 16:465-478.
6. Castagnera L, Maurette P, Pointillart V, Vital JM, Erny P, Senegas J. Long-term results of cervical epidural steroid injection with and without morphine in chronic cervical radicular pain. *Pain* 1994; 58:239-243.
7. Stav A, Ovadia L, Sternberg A, Kaadan M, Weksler N. Cervical epidural steroid injection for cervicobrachialgia. *Acta Anaesthesiol Scand* 1993; 37:562-566.
8. Pasqualucci A, Varrassi G, Braschi A, et al. Epidural local anesthetic plus corticosteroid for the treatment of cervical brachial radicular pain: Single injection versus continuous infusion. *Clin J Pain* 2007; 23:551-557.
9. Manchikanti L, Malla Y, Cash KA, McManus CD, Pampati V. Fluoroscopic epidural injections in cervical spinal stenosis: Preliminary results of a randomized, double-blind, active control trial. *Pain Physician* 2012; 15:E59-E70.
10. Manchikanti L, Malla Y, Cash KA, McManus CD, Pampati V. Fluoroscopic cervical interlaminar epidural injections in managing chronic pain of cervical post-surgery syndrome: Preliminary results of a randomized, double-blind active control trial. *Pain Physician* 2012; 15:13-26.
11. Manchikanti L, Cash KA, Pampati V, Wargo BW, Malla Y. Cervical epidural injections in chronic discogenic neck pain without disc herniation or radiculitis: Preliminary results of a randomized, double-blind, controlled trial. *Pain Physician* 2010; 13:E265-E278.
12. Manchikanti L, Cash KA, Pampati V, Malla Y. Fluoroscopic cervical epidural injections in chronic axial or disc-related neck pain without disc herniation, facet joint pain, or radiculitis. *J Pain Res* 2012; 5:227-236.
13. The National Uniform Claims Committee. Specialty Designation for Interventional Pain Management- 09.
www.cms.hhs.gov/transmittals/Downloads/r1779b3.pdf
14. Medicare Payment Advisory Commission. Report to the Congress: Paying for interventional pain services in ambulatory settings. Washington, DC: MedPAC. December. 2001.
www.medpac.gov/publications/congressional_reports/dec2001PainManagement.pdf
15. Graham R, Mancher M, Wolman DM, Greenfield S, Steinberg E (eds); Committee on Standards for Developing Trustworthy Clinical Practice Guidelines; Institute of Medicine. *Clinical Practice Guidelines We Can Trust*. The National Academies Press, Washington, DC, 2011.

16. Field MJ, Lohr KN (eds). Committee to Advise the Public Health Service on Clinical Practice Guidelines, Institute of Medicine. *Clinical Practice Guidelines. Directions for a New Program*. National Academy Press, Washington, 1990.
17. Manchikanti L, Falco FJE, Singh V, et al. An update of comprehensive evidence-based guidelines for interventional techniques of chronic spinal pain. Part I: Introduction and general considerations. *Pain Physician* 2013; 16:S1-S48.
18. Harris RP, Helfand M, Woolf SH, et al; Methods Work Group, Third US Preventive Services Task Force. Current methods of the US Preventive Services Task Force. *Am J Prevent Med* 2001; 20:21-35.